




PROVIDER NEWS

A newsletter for Highmark Blue Cross Blue Shield providers in western Pennsylvania

Issue 2, February 2024





The ability to submit **new** Claim Investigations in NaviNet will end after **February 29, 2024**.

You will continue to have view access to pending Claim Investigations in NaviNet up until complete shutdown on **March 29**. After this date, the outcome of any NaviNet Claim Investigations will be provided to you via a letter. Any new Claim Investigations should be submitted in the [Availity®](#)  portal, so that responses may be viewed within Availity after access to NaviNet ends.

Get Trained Now on Availity


NaviNet will be decommissioned for Highmark providers on **March 29**.

With access to NaviNet ending in little over a month, now is the time for you and your team get trained on using [Availity](#) . Don't wait until the last minute!

To get started, sign in to [Availity](#)  and click the **Help & Training** in the top website menu bar on the home page. Click **Get Trained** from the drop-down menu to view recorded demos and webinars. You can also sign up for future live webinars in Availity.



Use Availity for Your Highmark Transactions

All Highmark providers now have access to [Availity](#) . This means your organization should be using Availity to complete all new transactions for Highmark commercial and Medicare Advantage plans.

NOTE: *Highmark Wholecare and Highmark Health Options will not transition to Availity; providers should continue to use their current portals for transactions related to these plans.*

Administrators – Get Your Organization Ready

In Availity Essentials, access the **Manage My Organization** page to do the following:

- Register a new organization.
- Search for and check the status of registrations you have submitted.
- View and edit business information for existing organizations.
- Add new providers to your organization(s), or edit existing ones, for easy data entry when submitting transactions.

Additional Resources



Registration Guides

- [Availity Essentials Registration for Health Care Providers](#) 
- [Availity Essentials Registration for Billing Services](#) 

Reference Guides

- [Availity Essentials Reference Guide for Users](#) 
- [Availity Essentials Reference Guide for Administrators](#) 

PRC Resources

- [Availability page](#)  on the Provider Resource Center (PRC)
- [FAQs](#)  on the PRC

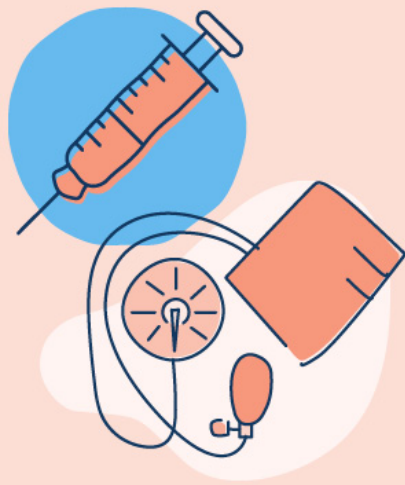




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Annual HEDIS[®] Medical Record Review Now Underway

The annual Healthcare Effectiveness Data and Information Set (HEDIS[®]) Medical Record Review is being conducted now through May 2024.

This review assesses provider compliance with a set of standardized performance measurements that we are required to report to the National Committee for Quality Assurance (NCQA). HEDIS data is collected and reported on an annual basis as part of our accrediting and governmental requirements.

The measurements being collected are:

- Controlling High Blood Pressure
- Colorectal Cancer Screening
- Hemoglobin A1c Control for Patients with Diabetes

- Blood Pressure Control for Patients with Diabetes
- Eye Exam for Patients with Diabetes
- Transitions of Care
- Cervical Cancer Screening
- Childhood Immunization Status
- Immunizations for Adolescents
- Lead Screening in Children
- Prenatal and Postpartum Care
- Weight Assessment and Counseling for Nutrition and Counseling for Physical Activity for Children and Adolescents



For information on who will be conducting this year's review and who to contact with your questions, please see the recent [Special Bulletin](#) .

Disclaimers:

HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

The following entities serve western and northeastern Pennsylvania and are independent licensees of the Blue Cross Blue Shield Association: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

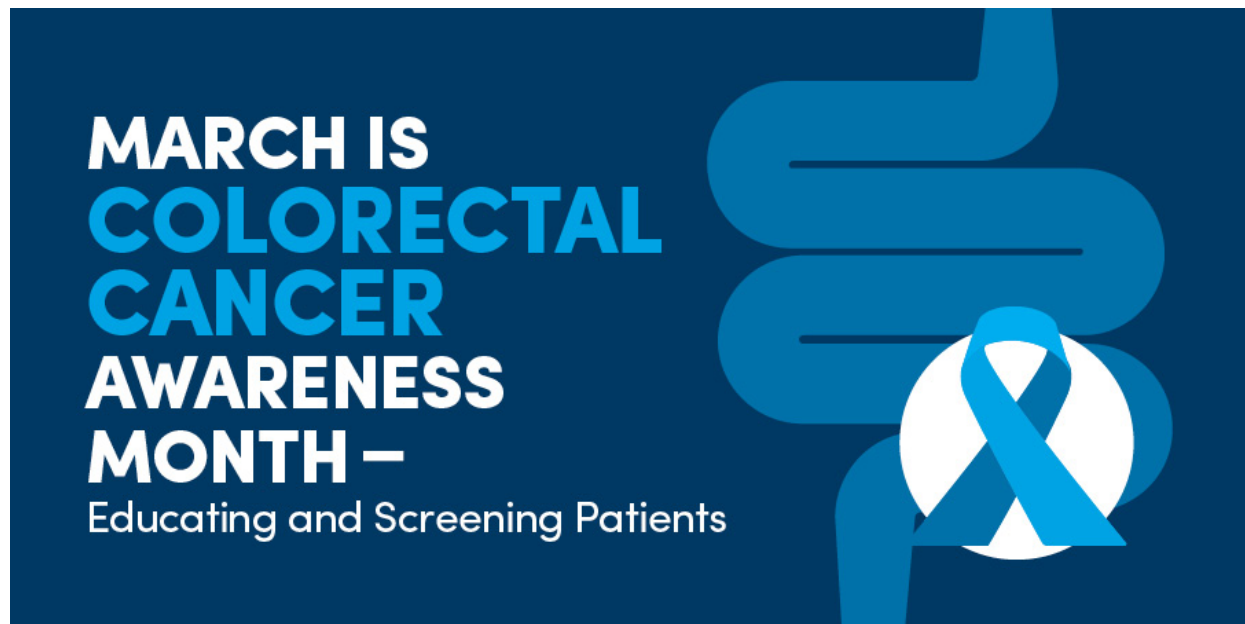






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Colorectal cancer is the most common cancer diagnosed in both men and women in the United States, according to the [Centers for Disease Control and Prevention \(CDC\)](#) . The [American Cancer Society](#)  estimates that more than 53,000 Americans will die from colorectal cancer in 2024.

Educating patients about the importance of screening for colorectal cancer saves lives. Highmark has educational resources available – that practices can order at no cost – to inform patients about the role screening plays in preventing and detecting colorectal cancer in its earliest stages.

Screening Starts at 45


The U.S. Preventive Services Task Force (USPSTF) recommends all adults be screened for colorectal cancer starting **at age 45**. Previously, it was age 50, but the USPSTF lowered the recommended age in 2022.

Individuals at an elevated risk – whether due to lifestyle factors and/or family history – may need earlier or more frequent screening.

[Highmark Preventive Health Guidelines](#)  include colorectal cancer screenings for eligible members. Please note that most, although not all, of our employer groups follow the Highmark Preventive Schedule. Therefore, not all Highmark members may have coverage for services on the preventive schedule.



Tier-1 Screenings

The [U.S. Multi-Society Task Force](#)  has classified the various colorectal cancer screening modalities based on performance and effectiveness. Colonoscopy and annual fecal immunochemical test (FIT) are both classified as a tier-1 screening recommendations.

Closing HEDIS[®] Gaps – A Higher Level of Care

Healthcare Effectiveness Data and Information Set (HEDIS[®]) measures the level of patient care provided by health care organizations and practitioners.

To meet the HEDIS measure for Colorectal Cancer Screening, the following screening tests will help close gaps in patient care:

- Colonoscopy within the last 10 years
 - Evidence in the medical record must indicate that the colonoscopy advanced past the splenic flexure to meet criteria as a colonoscopy. Otherwise, it will count as a sigmoidoscopy.
- Stool DNA (sDNA) with FIT-DNA (Cologuard) during the last three years
- Fecal occult blood test (gFOBT, iFOBT) during the measurement year
 - **NOTE:** A sample collected via digital rectal exam (DRE) or FOBT test performed in an office setting does **not** count for compliance.
- Computed tomography (CT) colonography within the last five years
- Flexible sigmoidoscopy within the last five years

Documentation must include a note indicating the date the colorectal cancer screening was performed. At a minimum, the YEAR must be specified.

It is not required to include a result if the screening date is clearly shown in the medical or surgical history. If the date is not clear, the result or finding must be included in the documentation to ensure the test was performed and not merely ordered.

Exclusions





The following required exclusions can be submitted on the claim to remove the member from the measure:

- Members who have had colorectal cancer or a total colectomy anytime during their medical history through Dec. 31 of the measurement year.
- Members in hospice, using hospice services, palliative care anytime, experiencing frailty and advanced illness, or who died during the measurement year.

Tip: A patient's refusal is NOT considered an exclusion.

Resources for Patients/Members

On the Provider Resource Center (PRC), practitioners can download the following free educational resources to share with patients and staff:

- [Colorectal Cancer Screening Brochure](#) 
- [Colorectal Cancer Screening Flyer](#)  (Spanish version available)
- [Colorectal Cancer Screening Reminder Card](#) 
- [Health Screening and Vaccination Tracker](#)  (Spanish version available)

To order copies for your practice, go to the **PRC > EDUCATION/MANUALS > Inventory Request Form > Select Printable Item**. Click the down arrow and then select the items you wish to order. Complete the form and click the **ADD TO ORDER** button.

Highmark does not recommend particular treatments or health care services. This information is not intended to be a substitute for professional medical advice, diagnosis, or treatment. You should determine the appropriate treatment and follow-up with your patient. Coverage of services is subject to the terms of each member's benefit plan. Additionally, state laws and regulations governing health insurance, health plans and coverage may apply and will vary from state to state.

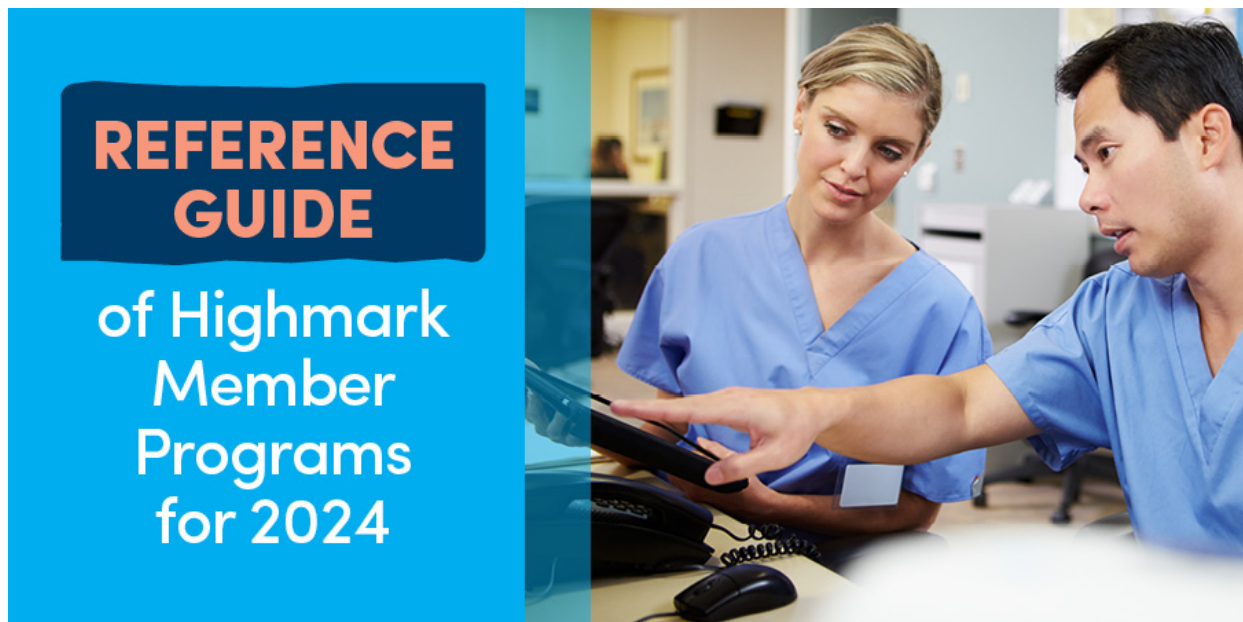





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When our members visit your office or facility this year, they may have questions about the programs and services available to them through Highmark.

To help you and your staff answer those inquiries, we recently published the [Reference Guide of Highmark Member Programs](#)  on the Provider Resource Center (PRC). The guide contains useful information and resources to give you and your team a comprehensive understanding of the programs offered to our members in all service areas.

This year's guide includes the following sections:

- Clinical Care
- Disease Management
- Specialty Case Management
- Diabetes

- Wellness and Prevention
- Comprehensive Lifestyle
- SDOH (Social Determinants of Health)
- Home Support Services
- Virtual Health
- Behavioral Health
- Virtual Specialized Mental and Behavioral Health
- Virtual Substance Use Disorder



Please be aware that programs may be discontinued or additional information may become available; if that occurs, the guide will be updated accordingly. Also, coverage for each program may vary based on member benefits and members should consult their individual plans for coverage details.

To access the guide, go to the PRC, select **EDUCATION/MANUALS**, and then click **Reference Guide Of Highmark Member Programs**.





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SHORT TAKES:



Inpatient Admissions, HEDIS Changes, and Hemophilia Drug Program


Inpatient Admissions: Reconsideration Requests for “No Clinical Information” Denials

Facility providers should submit a reconsideration request for denied admissions for Commercial inpatient medical care due to **a lack of clinical information** on the original authorization submission. **NOTE:** *Reconsideration requests only apply to Commercial lines of business.* To read the **Special Bulletin**, click [here](#) .

HEDIS Changes in 2024: Diabetes, Cervical and Colorectal Cancer Screenings

The 2024 Healthcare Effectiveness Data and Information Set (HEDIS[®]) includes changes to the following measurements:

1. Diabetes
2. Cervical Cancer Screening
3. Colorectal Cancer Screening


To learn more about the changes, click [here](#) .

Hemophilia and Bleeding Disorder Drug Program: New Pharmacy and Drugs Added

Effective March 1, 2024, Alliance Rx Walgreens Pharmacy is being added as an exclusive specialty pharmacy for members in Highmark's Hemophilia and Bleeding Disorder Drug Program. The other two pharmacies in the program are Soleo Health and the Hemophilia Treatment Center of Western Pennsylvania. Option Care Health will no longer be participating in the program effective March 1, 2024.

In addition, the following three drugs will be available through the program on **March 1, 2024**:

- J7199 - Altuviiio
- J7204 - Esperoct
- J7212 - Sevenfact

To learn more, click [here](#) .

Medical Policy S-123 Published on Jan. 22, 2024

The publication of **Medical Policy (MP) S-123 Lung and Lobar Lung Transplant** was delayed. Originally scheduled for Jan. 15, 2024, the policy was published on Jan. 22, 2024. To view MP S-123, go to the Provider Resource Center. On the top task bar, click the drop-down arrow for **MEDICAL POLICY SEARCH**, select **MEDICAL POLICIES**, and then type "S-123" into the search bar.





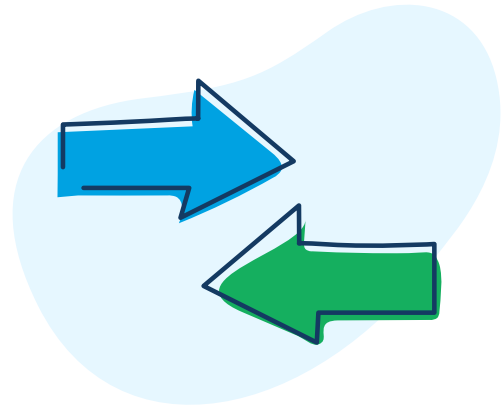
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New and Updated Reimbursement Policies

Highmark regularly issues new or updated reimbursement policies. Keep an eye on this newsletter and the Provider Resource Center (PRC) homepage for announcements regarding upcoming policy changes. As specific policy changes go into effect, the updated policies can be found on the Reimbursement Policy page of the PRC.



Below is a list of recent and upcoming updates to reimbursement policies (RPs):

RECENTLY UPDATED

February 5, 2024

RP-033 [Anesthesia Services](#) 

This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-038 [Out of Network Services](#) 

This policy was reviewed as part of our standard review process. No changes in direction were made.

RP-039 [Outpatient Services Prior to An Inpatient Admission](#) 

This policy was reviewed as part of our standard review process. No changes in direction were made.

February 19, 2024

MRP-004 [Prolonged Services](#)

Effective **Feb. 19, 2024**, this policy was archived. The direction of this policy was merged into a new version of RP-034 (see below), which went into effect **Feb. 19, 2024**.

RP-034 [Prolonged Detention or Critical Care](#)

This policy was updated to include Medicare Advantage direction merged from MRP-004 (see above).

RP-063 [Consultation Services](#)

This policy was reviewed as part of our standard review process. No changes in direction were made.

UPCOMING

April 1, 2024

RP-034 [Prolonged Detention or Critical Care](#)

Code 93598 will be added to the “Prolonged Detention or Critical Care” section of this policy.

April 29, 2024

RP-041 [Services Not Separately Reimbursed](#)

Code 76140 will be added and will no longer be a separately reimbursed service.

May 1, 2024

RP-026 [Portable Radiography and ECG Services – Modifiers UN, UP, UQ, UR, US](#)

Direction for “U” modifier reductions reported with code R0075 will be made applicable for Commercial.



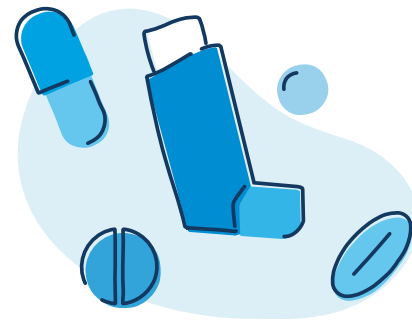



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Quarterly Formulary Updates



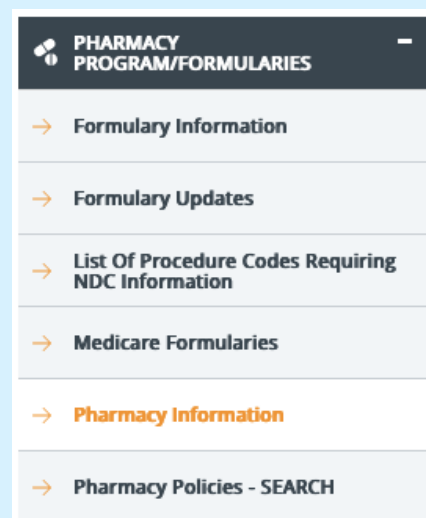
View the [December 2023 updates](#)  to Highmark's prescription drug formularies and related pharmaceutical management procedures at the Formulary Updates page on the **Provider Resource Center (PRC)**. From the left menu, select **PHARMACY PROGRAM/FORMULARIES** and then **Formulary Updates**.

Pharmaceutical Management Procedures

To learn more about how to use these procedures, go to the **PHARMACY PROGRAM/FORMULARIES** section on the PRC. Click on **Pharmacy Information** from the sidebar and then **Pharmaceutical Management** from the list on the right.


This section includes information on:

- Exception requests
- The process for generic substitutions
- Explanations of limits/quotas, therapeutic interchange, and step-therapy protocols




Federal Employee Program (FEP) Drug Formularies and Pharmaceutical Management Procedures

The FEP specific drug formularies are available [online](#) . Providers also may obtain formulary information by calling **866-763-3608** and following the prompts for *Pharmacy*.

To learn more about the FEP exception request processes for non-formulary drugs, click [here](#) .



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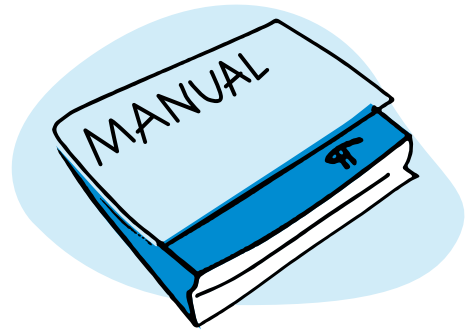
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Staying Up to Date with the *Highmark Provider Manual*

Ensure you are regularly reviewing the [Highmark Provider Manual](#)  for our most recent guidance on:

- Participation Rules
- Credentialing/Recredentialing Criteria and Procedures
- Medical Record Criteria
- Requirements for 24/7 Coverage



Some recent noteworthy changes include:

- **Chapter 2, Unit 2: Medicare Advantage Products & Programs**
- **Chapter 2, Unit 6: The BlueCard Program**
- **Chapter 6, Unit 1: General Claim Submission Guidelines**
- **Chapter 6, Unit 2: Electronic Claim Submission**
- **Chapter 6, Unit 8: Payment Review**

To see the full list of recent changes, visit the [Highmark Provider Manual Changes](#)  page.





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Directory Information – Here's How to Attest



When Highmark members are looking for a primary care physician (PCP) or specialist, they expect that our online provider directory presents information that is accurate and current.

That's why it is essential to ensure that your practice information on file with Highmark remains up to date.

Please be aware that providers who don't validate their data quarterly may be removed from the directory and their status within Highmark's networks may be impacted.

Reviewing Data Is Vital for You

The Centers for Medicare and Medicaid Services (CMS) requires Highmark to reach out to you every quarter and ask you to validate your provider directory information. We use this information to populate our online provider directory and to help ensure correct claims processing.



Your thorough review of your directory information confirms:

- **Each practitioner's name** is correct and matches the name on his/her medical license.
- **Each practitioner's National Provider Identifier (NPI) is correct.**

- **The practice name is correct** and matches the name used when you answer the phone.
- **All specialties are correctly listed** and are currently being practiced.
- **Practitioners listed at a location** currently see members and schedule appointments at that office on a regular basis.
 - All practitioners listed must be affiliated with the group. Practitioners who cover, read test results, or are hospitalists should not be listed in the provider directory.
- **The practitioner is accepting new patients** – or not accepting new patients – at the location.
- **The practitioner’s address**, suite number (if any), and phone number are correct.






Professional Providers – Use the PDM Tool

Professional providers are now required to validate their Highmark Provider Directory information within the Provider Data Maintenance (PDM) tool in the provider portal – either [Availity](#)[®]  or [NaviNet](#)[®]  – every 90 days.


Facility, Ancillary, and Medicaid Providers – Use Atlas

The attestation process through Atlas is quick and easy. Just follow these steps...

1. Go to hub.primeatlas.com .
2. Log in.
3. Review your information.
4. If no changes, confirm.
5. If there are changes, update your information.

If you haven’t attested your provider directory information this quarter, you will receive a letter from Atlas to review your provider information. Some providers may also receive emails from Highmark about validating their directory information through the [Atlas website](#) . To ensure delivery of emails from Highmark, please add the following email address, resourcecenter@highmark.com , to your address book.

During the attestation process, always double-check your current email address(es) to ensure that you can receive electronic communications from Highmark without delay.

If you need additional information regarding the attestation process, [Atlas' step-by-step guide](#)  is available on the Provider Resource Center.





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About This Newsletter

Provider News is a valuable resource for health care providers who participate in our networks. Published monthly on the last Monday of the month*, *Provider News* conveys important product, policy, and administrative information, including billing, claims, and program updates.


The publication also features the latest news, information, tips, and reminders about our products and services, as well as relevant interviews, articles, and stories, for health care professionals who serve Highmark members.

Regular topics include:

- New and Updated Reimbursement Policies
- Authorization Updates
- Staying Up to Date with the *Highmark Provider Manual*


*When a holiday falls on the last Monday of the month, *Provider News* will be published on the preceding Friday.

Another Valuable Resource

For medical policy and claims administration updates, including coding guidelines and procedure code revisions, please refer to the [Medical Policy Update Newsletter](#) .


You can access both *Provider News* and the Medical Policy Update Newsletter on the Provider Resource Center from the **NEWSLETTERS/NOTICES** link on the sidebar. Email subscriptions are available via the **eSubscribe** button on the PRC taskbar.

Comments/Suggestions Welcome

We want *Provider News* to meet your needs for timely, effective communication. If you have any suggestions, comments, or ideas for articles in future issues, please email the *Provider News* team at ResourceCenter@Highmark.com .



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Legal Information

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Highmark Senior Health Company and Highmark Coverage Advantage are service marks of Highmark Inc. Highmark Health is the parent company of Highmark Inc.

The Blue Cross Blue Shield Association is an association of independent, locally operated Blue Cross and Blue Shield companies.

Atlas Systems, Inc. is a separate and independent company that conducts physician outreach for Highmark.

NaviNet is a registered trademark of NaviNet, Inc., which is an independent company that provides a secure, web-based portal between providers and health care insurance companies.

Current Procedural Terminology (CPT) is a registered trademark of the American Medical Association. Healthcare Effectiveness Data and Information Set (HEDIS)[®] and Quality Compass[®] are registered trademarks of the National Committee for Quality Assurance (NCQA). Consumer Assessment of Healthcare Providers and Systems (CAHPS)[®] is a registered trademark of the Agency for Healthcare Research and Quality. CORE is a registered trademark of CAQH.

Note: This publication may contain certain administrative requirements, policies, procedures, or other similar requirements of Highmark (or changes thereto) which are binding upon Highmark and its contracted providers. Pursuant to their contract, Highmark

and such providers must comply with any requirements included herein unless and until such item(s) are subsequently modified in whole or in part.



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QUICK REFERENCE

HIGHMARK PROVIDER SERVICE CENTERS

Please use NaviNet® for all of your routine eligibility, benefit, and claim inquiries.
For non-routine inquiries that require analysis and/or research, contact Highmark's Provider Services.

[What Is My Service Area?](#)

PENNSYLVANIA:

- Western Region: Professional Providers **1-800-547-3627**; Facilities **1-800-242-0514**
Hours of Availability: 8 a.m. to 5 p.m. EST, Monday through Friday
- Central & Northeastern Regions: Professional Providers **1-866-731-8080**; Facilities **1-866-803-3708**
Hours of Availability: 8 a.m. to 5 p.m. EST, Monday through Friday
- Eastern Region **1-800-975-7290**
Hours of Availability: 9 a.m. to 12 noon, 1 p.m. to 4:30 p.m. EST, Monday through Friday.
- Medicare Advantage:
 - Freedom Blue PPO: **1-866-588-6967**
 - Community Blue Medicare HMO: **1-888-234-5374**
 - Community Blue Medicare PPO: **1-866-588-6967**
 - Security Blue HMO (Western Region only): **1-866-517-8585**
- Behavioral Health:
 - Western & Northeastern Regions: **1-800-258-9808**
 - Central & Eastern Regions: **1-800-628-0816**

DELAWARE:

- Highmark Delaware Provider Services: **1-800-346-6262**
Hours of Availability: 8:30 a.m. to 5 p.m. EST, Monday through Friday
- Behavioral Health: **1-800-421-4577**

WEST VIRGINIA:

- Highmark West Virginia Medical: **1-800-543-7822**
- Highmark Senior Solutions Medicare Advantage Freedom Blue PPO: **1-888-459-4020**
Hours of Availability: 8 a.m. to 8 p.m. EST, Monday through Sunday
- Behavioral Health: **1-800-344-5245**

NEW YORK:

- Highmark Blue Cross Blue Shield of Western New York: **1-800-950-0051 or (716) 884-3461**
- Highmark Blue Shield of Northeastern New York: **1-800-444-4552 or (518) 220-5620**
Hours of Availability: 8 a.m. to 8 p.m. EST, Monday through Sunday
- Behavioral Health: **1-844-946-6264**
 - Fax: Behavioral Health Outpatient: **1-822-581-1867**; Behavioral Health Inpatient **1-833-581-1866**

Please listen carefully to the available options to reach the appropriate area for your inquiry.

HIGHMARK CLINICAL SERVICES

NaviNet® is the preferred for authorization requests. Contact Clinical Services for inquiries that cannot be handled via NaviNet.® **Hours of Availability:** Monday-Friday 8:30 a.m.-7 p.m.; Saturday & Sunday 8:30 a.m.-4:30 p.m. for urgent issues.

PENNSYLVANIA:

- Western Region:
 - Medical Services: Professional Providers **1-800-547-3627**; Facilities **1-800-242-0514**
 - Behavioral Health: **1-800-258-9808**

